

Uterine preservation surgery in placenta accreta spectrum

Arun B¹, Arundhati G¹, Sarah Li, Lim Tak Yein, Biswas Arijit

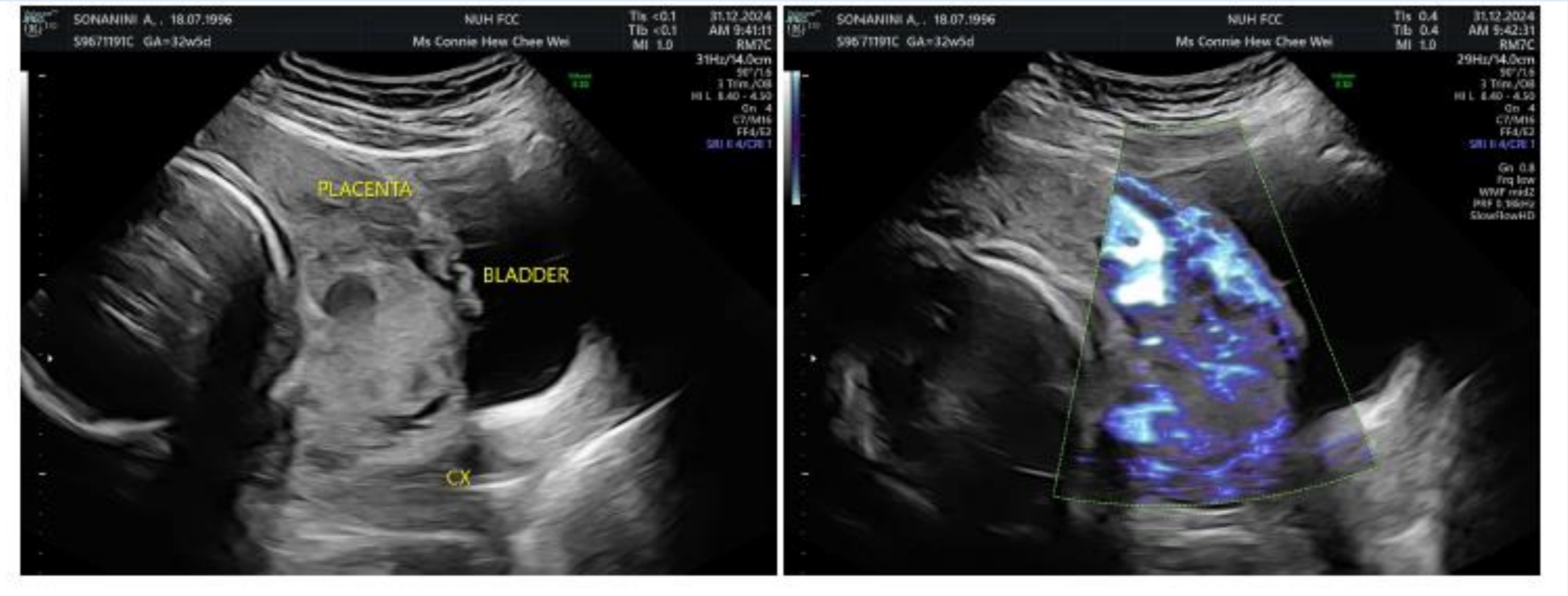
1 National University Hospital, Department of Obstetrics and Gynaecology, Singapore

Introduction

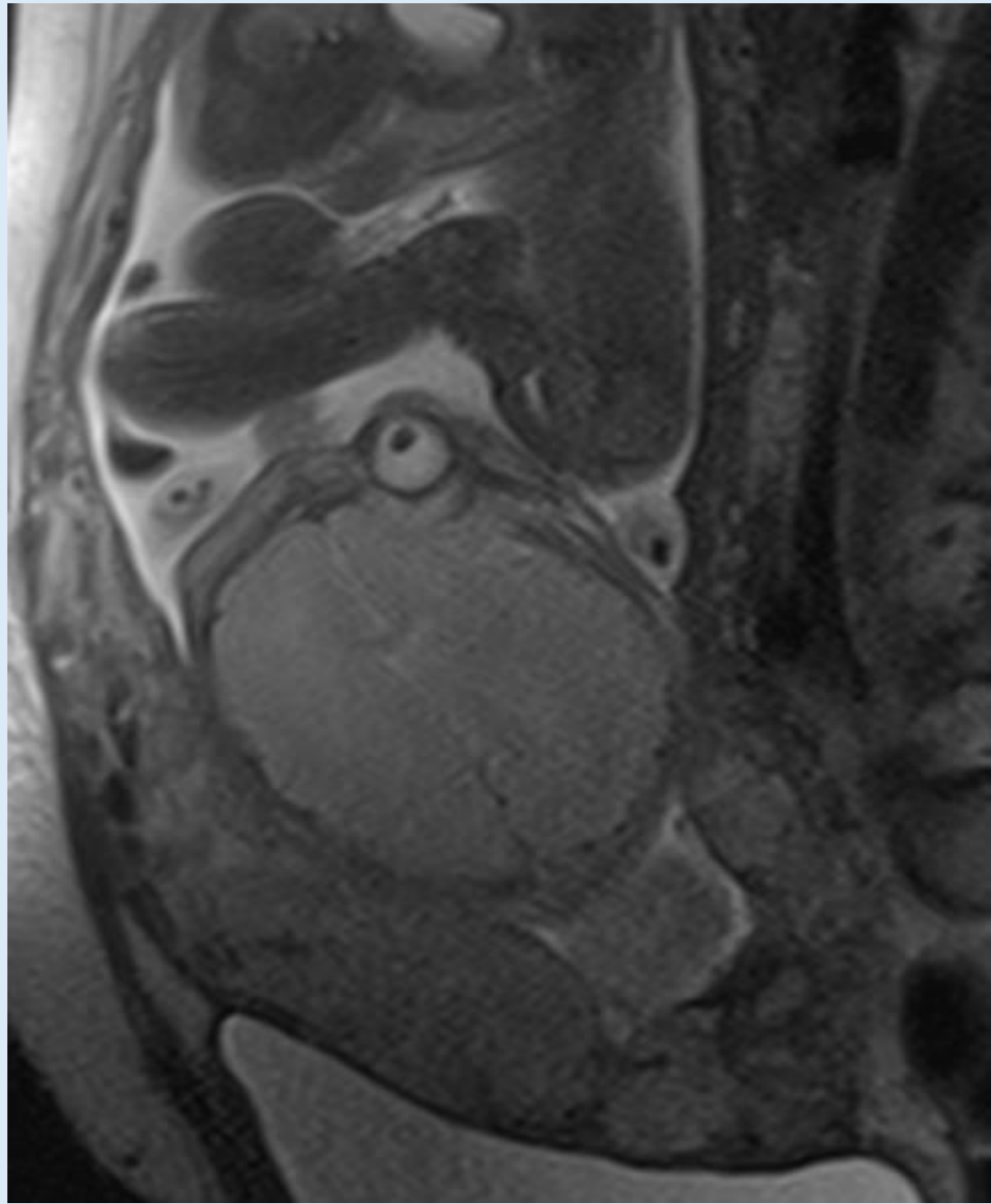
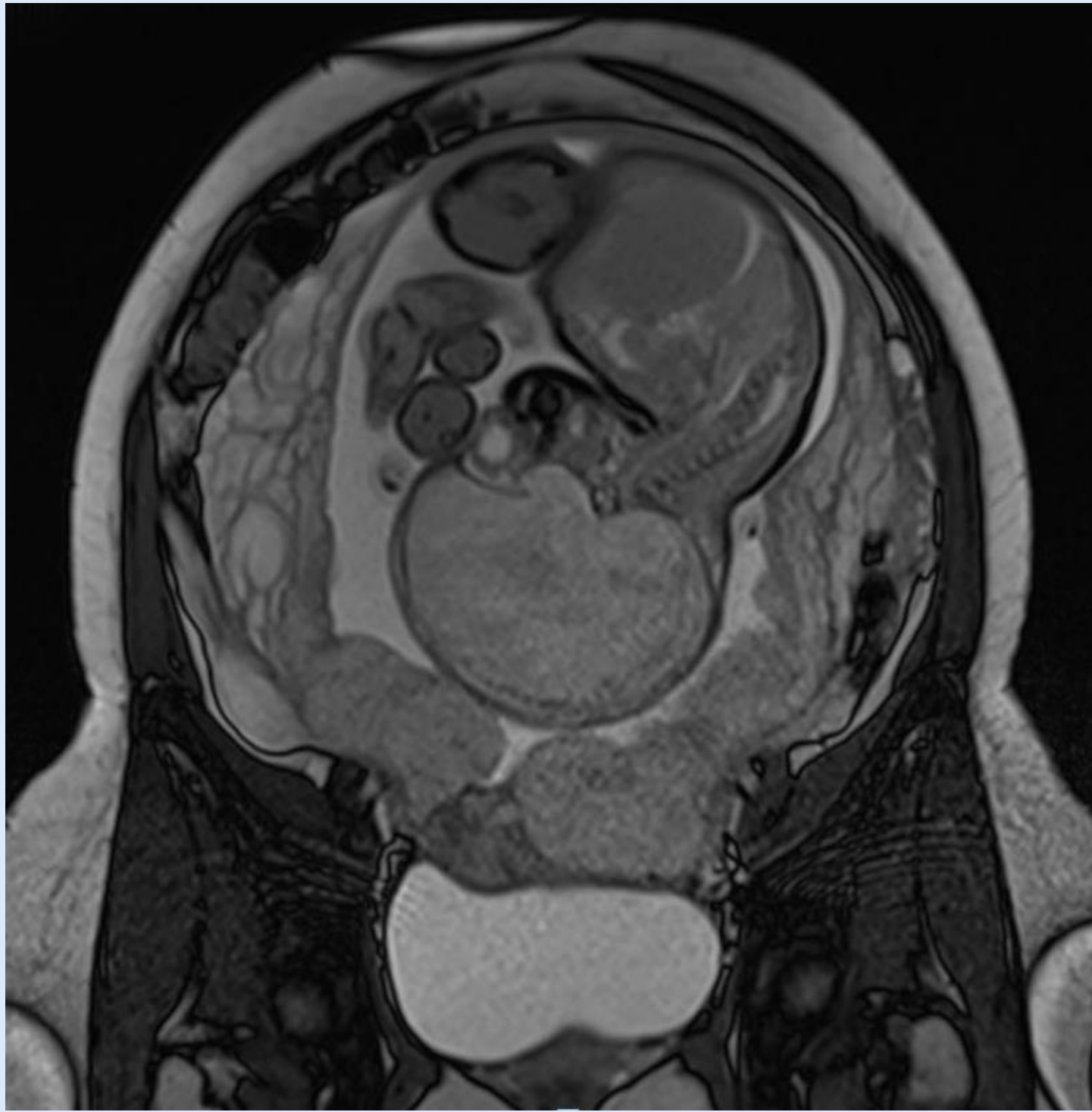
Placenta accreta spectrum (PAS) is a potentially life-threatening complication of pregnancy. Patients are usually diagnosed during the early second trimester or later. Classically, patients have massive PPH and a caesarean hysterectomy would be the standard treatment for most cases of PAS to minimize blood loss and complications.

Case report

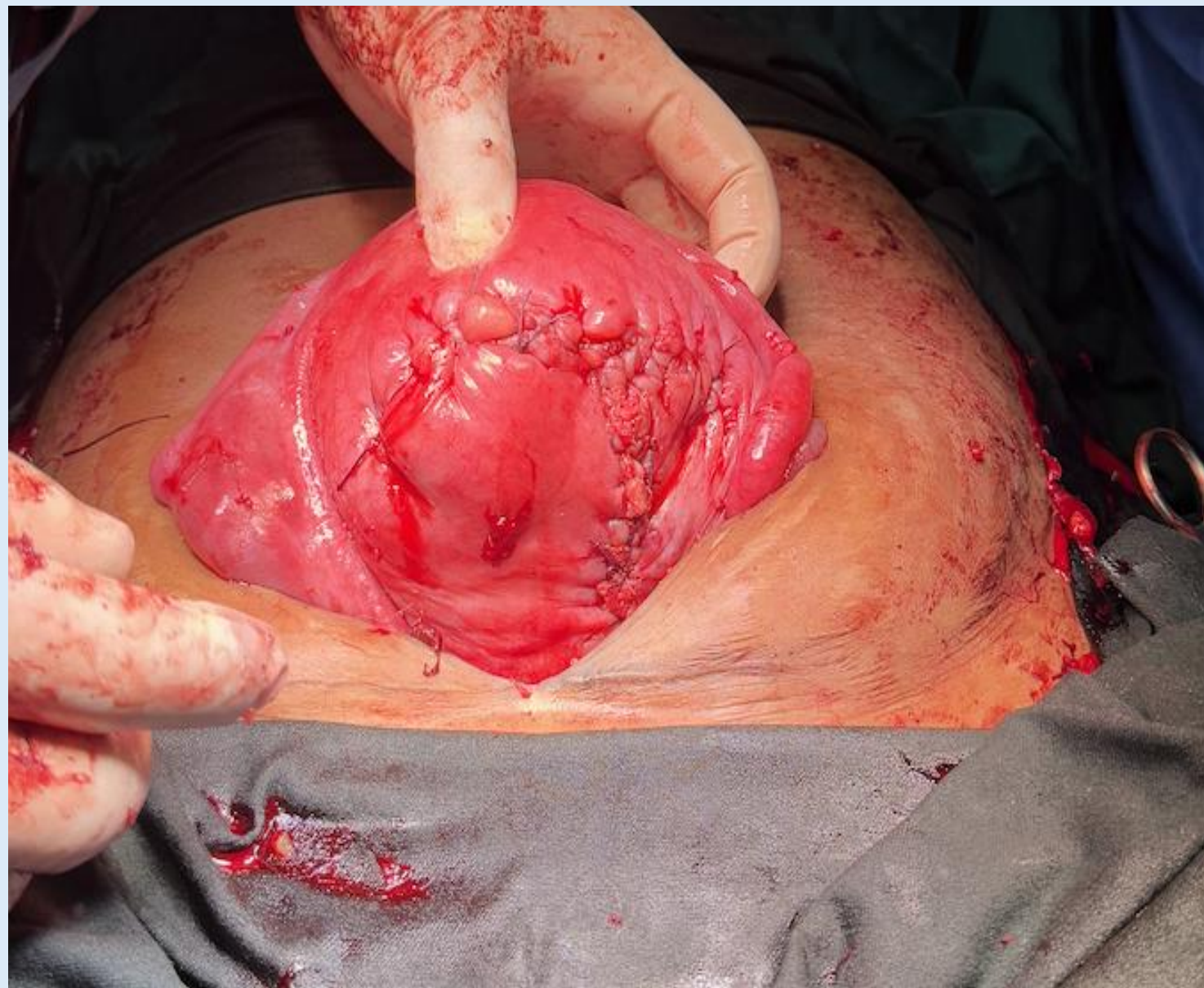
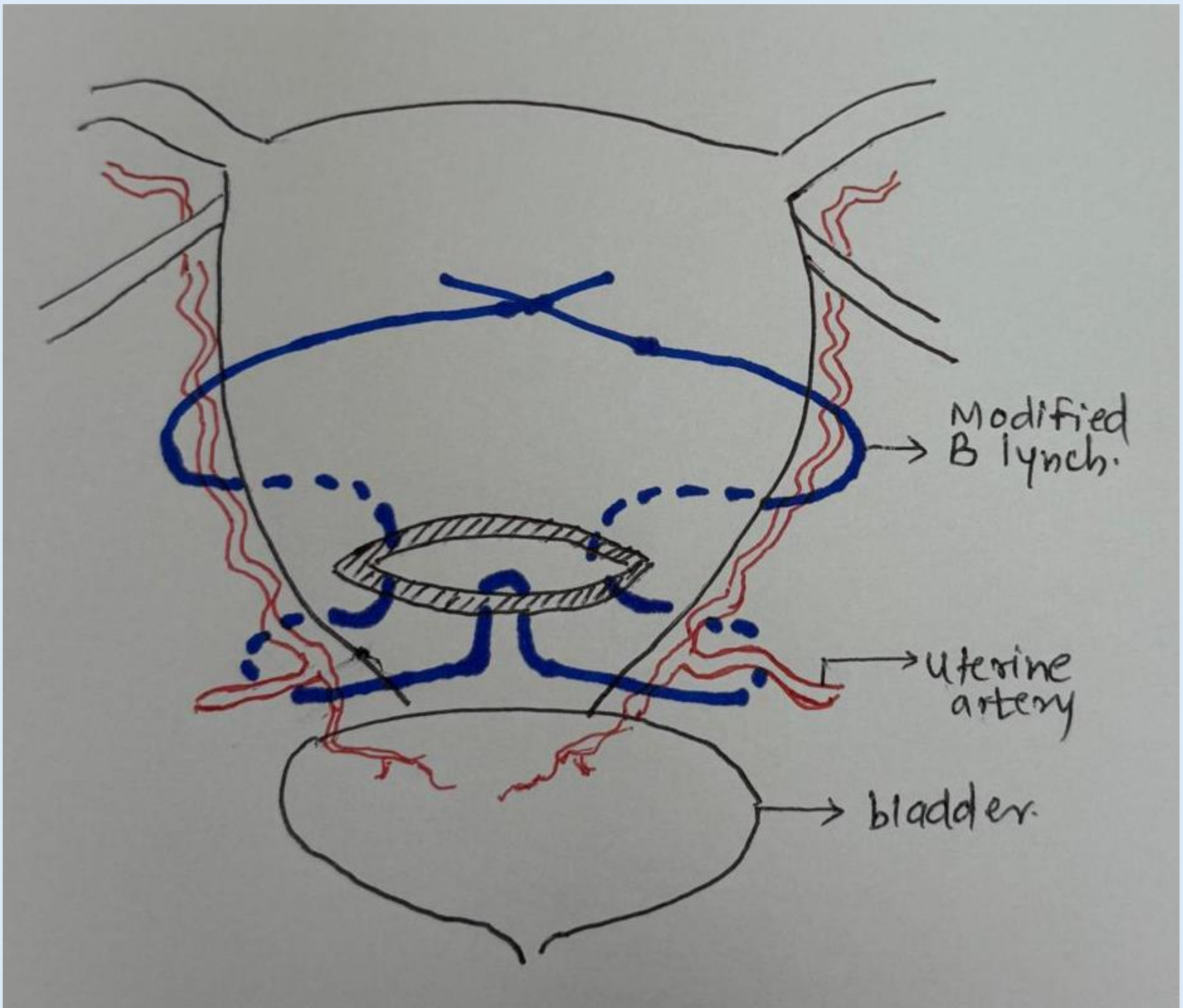
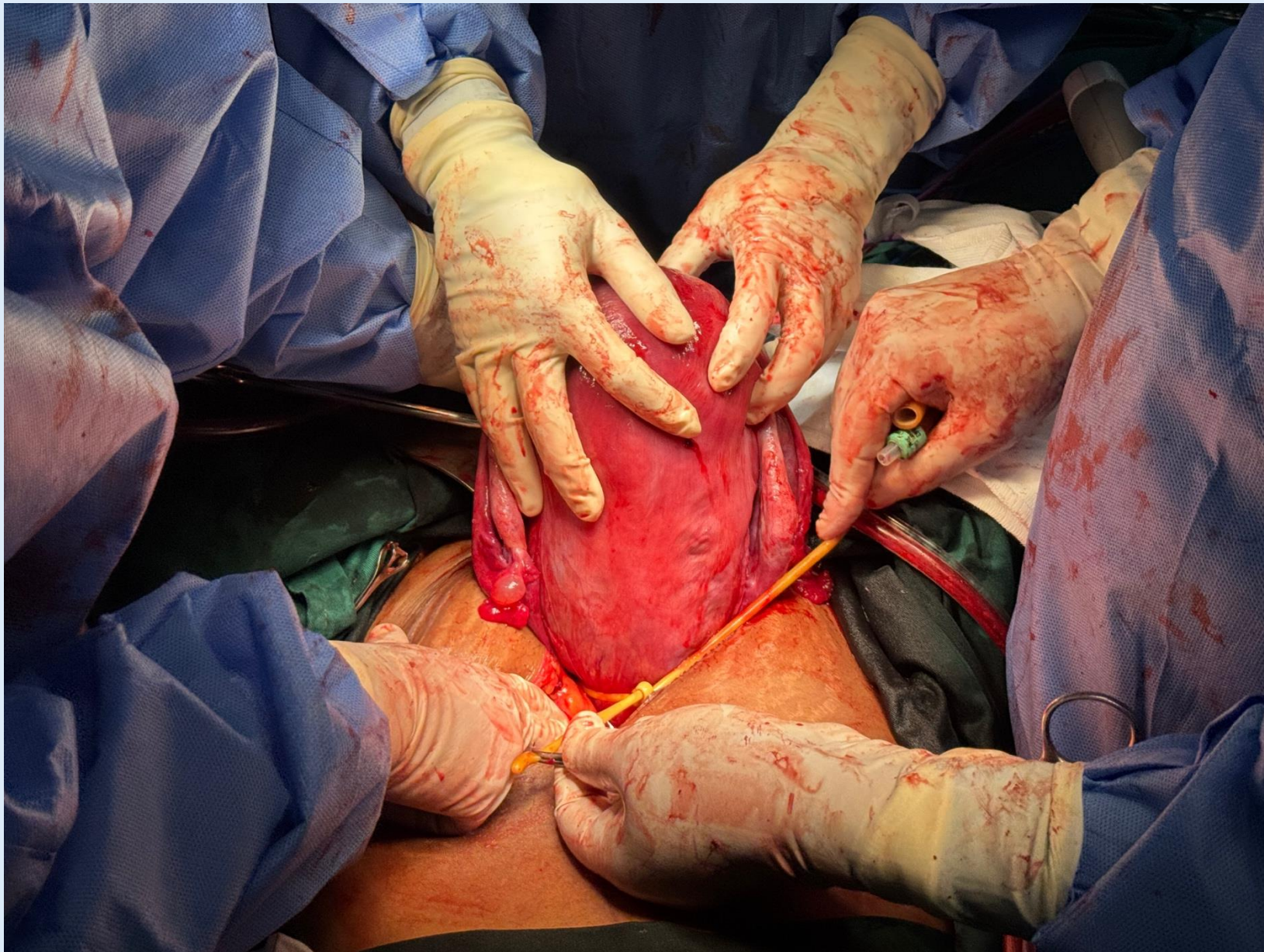
28-year-old Singaporean lady, with one previous uncomplicated emergency Caesarean 4 years ago, who was diagnosed with anterior right lateral placenta praevia major during her routine fetal anomaly scan(GA 20wk). A repeat scan at 30 weeks was highly suspicious for placenta accrete spectrum with loss of hypoechoic space measuring 5x4 cms over the previous scar, increased vascularity and presence of multiple lacunae, and thin overlying myometrium. She presented with fetal demise at 32 weeks. She had a fetal MRI confirming placenta accreta with area of 6x5 cm at the UV fold and below that, but no involvement of bladder.



Pre-surgery planning involved the high-risk obstetrics team, a maternal fetal medicine specialist, interventional radiology, and obstetric anaesthesiologists



Operative procedure
Internal iliac artery embolization with gel foam
Midline, infraumbilical, vertical skin incision
Enter parametrial spaces beneath the round ligament to access lateral margin of placental bulge
Enter utero vesical space bluntly from both sides to see if fingers can meet and push the UV fold down
High transverse uterine incision above placental border and deliver baby
Exteriorize uterus, tourniquet around the utero-cervical junction (left image)
Ligation of uterine vessels bundle
Separation of placenta, starting posteriorly until resistance met and adherent regions mapped out.
Cut off the non adherent part to improve visibility
Resection of adherent part with myometrium
Modified Criss cross B lynch (central image)
Tension-less reconstruction of uterine incision defect and refashion uterus in 2 layers (right image)



Operative details

EBL 2500 ml of blood, requiring 3 PCTS, remained hemodynamically stable during the surgery. Total Surgical time was 130 minutes.

Post surgery recovery

High-dependency Unit for 18 hours
Post operative recovery was uneventful with adequate pain control
She was discharged on post-operative day 4.